ENROLLED ORIGINAL

AN ACT

Codification District of Columbia Code **2001 Supp.**

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To allow for joint negotiation by competing physicians of certain terms and conditions of contracts with health plans.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the “Physicians Negotiation Act of 2000".

Sec. 2. Findings.

The Council finds that joint negotiation by competing physicians of certain terms and conditions of contracts with health plans will result in pro-competitive effects in the absence of any express or implied threat of retaliatory joint action, such as a boycott or strike, by physicians. Although the Council finds that joint negotiations over fee-related terms may in some circumstances yield anticompetitive effects, it also recognizes that there are instances in which health plans dominate the market to such a degree that fair negotiations between physicians and the plans are unobtainable absent any joint action on behalf of the physicians. In these instances, health plans have the ability to virtually dictate the terms of the contracts they offer physicians. Consequently, the Council finds it appropriate and necessary to authorize joint negotiations on fee-related and other issues where it determines that such imbalances exist.

Sec. 3. Joint negotiation allowed.

(a) Competing physicians within the service area of a health plan may meet and communicate for the purpose of jointly negotiating the following terms and conditions of contracts with the health plan:

(1) Clinical practice guidelines and coverage criteria;

(2) Respective physician and health plan liability for the treatment or lack of treatment of health plan enrollees;

(3) Administrative procedures, including methods and timing of physician payments for services;

(4) Dispute resolution procedures relating to disputes between health plans and physicians;

(5) Patient referral procedures;
(6) Formulation and application of reimbursement methodology;
(7) Quality assurance programs;
(8) Health service utilization review procedures;
(9) Health plan physician selection and termination criteria; and
(10) Decisions of whether to engage in selective contracting.

(b) Nothing in this act shall be construed to allow boycotts by competing physicians.

(c) No competing physician shall enter into, or aid in the construction of, any agreement to restrict the ability of, or facilitate the refusal of, any physician to negotiate with a health plan on an individual basis or through any other arrangement.

Sec. 4. Joint negotiation disallowed.

(a) Except as provided in section 5, competing physicians shall not meet or communicate for the purposes of jointly negotiating the following terms and conditions of contracts with health plans:

(1) The fees or prices for services, including those arrived at by applying any reimbursement methodology procedures;

(2) The conversion factor in a resource-based relative value scale reimbursement methodology or similar methodologies;

(3) The amount of any discount on the price of services to be rendered by physicians;

(4) The dollar amount of capitation or fixed payment for health services rendered by physicians to health plan enrollees;

(5) The inclusion or alteration of terms and conditions to the extent they are the subject of government regulation prohibiting or requiring the particular term or condition in question; except that, such restriction shall not limit physician rights to collectively petition the government for a change in such regulation;

(6) To eliminate or limit access to services provided by other health care providers; or

(7) To eliminate or limit plan participation by other health care providers.

(b) Except as provided in section 5, competing physicians shall not meet or communicate for the purposes of jointly negotiating with the primary purpose of requiring, or not requiring, physician supervision of a provider who is acting within the scope of that provider's practice as determined by law.

(c) Nothing in this act shall prohibit or impede the implementation of section 603(d) of the District of Columbia Health Occupations Revision Act of 1985, as amended by section 2(r) of the Health Occupations Revision Act of 1985 Amendment Act of 1994.

Sec. 5. Exception where a health physician has substantial market power.

(a) Competing physicians within the service area of a health plan may jointly negotiate the terms and conditions specified in section 4(a), except paragraphs 6 and 7 of that subsection, where the health plan has substantial market power. Substantial market power shall be found where the health plan's market share exceeds 15% as measured by the number of covered lives as reported by the Commissioner of Insurance and Securities Regulation ("Commissioner"), or where the Commissioner determines that the power of the health plan significantly exceeds the countervailing market power of the physicians acting individually.

(b) The Department of Insurance and Securities Regulation shall have the authority to collect and investigate information necessary to determine on an annual basis the following:

(1) The average number of covered lives per month by every health plan in the District;

(2) The impact, if any, of the provisions of this section on health care costs in the District;

(3) The impact, if any, of the provisions of this section on the availability of health insurance; and

(4) The impact, if any, of the provisions of this section on the quality of care.

Sec. 6. Third party representatives.

Competing health care physicians' exercise of joint negotiation rights granted by sections 3 and 5 shall conform to the following criteria:

(1) Physicians may communicate with each other with respect to the contractual terms and conditions to be negotiated with a health plan;

(2) Physicians may only negotiate with health plans through a third party representative authorized to negotiate on their behalf.

(3) Physicians may communicate with the third party representative who is authorized to negotiate on their behalf with health plans over these contractual terms and conditions;

(4) The third party representative shall be the sole party authorized to negotiate with health plans on behalf of the physicians as a group;

(5) Physicians shall be bound by the terms and conditions negotiated by the third party representative;

(6) Health plans communicating or negotiating with a third party representative shall remain free to contract with or offer different contract terms and conditions to individual competing physicians not represented by the third party representative; and

(7) The third party representative shall not represent more than 30% of the market of practicing physicians for the provision of services or a particular physician type or specialty in the service area or proposed service area of a health plan with less than 5% of the market, as measured by the number of covered lives as reported by the insurance commissioner

or the actual number of consumers of prepaid comprehensive health services.

Sec. 7. Requirements for third party representatives.

Any person or organization acting as a third party representative of physicians for the purpose of exercising any authority granted under this act shall comply with the following requirements:

(1) Before engaging in any joint negotiations with health plans on behalf of physicians, the third party representative shall furnish for the Mayor’s approval the following:

(A) A report identifying the third party representative's name and business address;

(B) The names and addresses of physicians who will be represented by the identified representative;

(C) The relationship of the physicians requesting collective representation to the total population of physicians in the District;

(D) The proportion of the physicians requesting third party representation to the total population of practicing physicians by particular physician type or specialty in the service area of the health plan;

(E) The health plans with which the representative intends to negotiate on behalf of the identified physicians;

(F) The proposed subject matter of the negotiations or discussions with the identified health plans;

(G) The representative's plan of operation and procedures to ensure compliance with this section;

(H) The expected impact of the negotiations on the quality of patient care; and

(I) The benefits of a contract between the identified health plan and physicians.

(2) If the parties identified in the initial filing have failed to reach agreement, the parties may request the Mayor to appoint an arbitrator or mediator certified by the Mayor as one having knowledge in the health care and health insurance area. The cost of such arbitrator or mediator shall be borne by the parties.

(3) After the parties identified in the initial filing have reached an agreement, the representative shall furnish for the Mayor's approval a copy of the proposed contract and plan of action.

(4) Within 14 days of a health plan decision declining negotiation, terminating negotiation, or failing to respond to a request for negotiation, the representative shall report to the Mayor that negotiations have ended.

Sec. 8. Approval of submissions by third party representatives.

(a) The Mayor shall either approve or disapprove an initial filing, supplemental filing or a proposed contract within 30 days of filing. If the Mayor disapproves an initial filing, supplemental filing, or a proposed contract, the Mayor shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies could be corrected. A representative who fails to obtain the Mayor's approval is deemed to act outside the authority granted under this act.

(b) The Mayor shall approve a request to enter into joint negotiations or a proposed contract if the Mayor determines that the applicants have demonstrated that the likely benefits resulting from the joint negotiation or proposed contract outweigh the disadvantages attributable to a reduction in competition that may result from the joint negotiation or proposed contract.

(c) An initial filing approved pursuant to this act shall remain effective until the end of the negotiation as determined under section 7(3) or (4). If the health plan notifies the representative that it wishes to resume negotiations within 60 days of the end of the prior negotiations, the representative may renew the previously approved negotiations, upon notification to the Mayor, without obtaining a separate approval of the renewal.

(d) If the Mayor does not issue a written approval or rejection of an initial filing, supplemental filing, or proposed contract within the specified time period, the applicant shall have the right to petition the court for a mandamus order requiring the Mayor to approve or disapprove the contents of the filing forthwith.

Sec. 9. Reduction, limitation, boycott, or cessation of health care services not allowed.

Nothing contained in this act shall be construed to enable physicians to jointly coordinate any reduction, limitation, boycott, or cessation of health care services. The representative of the physicians shall advise physicians of the provisions of this section and shall warn of the potential for legal action against physicians who violate state or federal antitrust laws by exceeding the authority granted under this section.

Sec. 10. Report on the effectiveness of this act.

The Mayor shall conduct a study and submit a report to the Council detailing the effect of this act during the 6-month period which begins 3 years after the effective date of this act. The report shall include data on the number of negotiations conducted, the number of negotiations which resulted in agreements approved by the Mayor, the number of negotiations which resulted in agreements that were not approved, data detailing the cost of, and any disparate impact of this act, if any, on health care delivery within the District.

Sec. 11. Rulemaking; costs.

(a) The Mayor shall, pursuant to title 1 of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Code § 1-1501 *et seq*.), issue

rules and regulations to implement the provisions of this act. The proposed rules and regulations shall be submitted to the Council for a 45-day period of review, excluding Saturdays, Sundays, legal holidays and days of Council recess. If the Council does not approve or disapprove the proposed rules and regulations, in whole or in part, by resolution within the 45-day review period, the proposed rules and regulations shall be deemed approved.

(b) Any costs incurred by this process shall be borne equally by the parties involved in the negotiation, in accordance with regulations issued by the Commissioner, and all revenues collected by the Commissioner shall be deposited into the Insurance Regulatory Trust Fund, established by section 3 of the Insurance Regulatory Trust fund Act of 1993, effective October 21, 1993 (D.C. Law 10-40; D.C. Code § 35-2702).

Sec. 12. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Code § 1-233(c)(3)).

Sec. 13. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), approval by the Financial Responsibility and Management Assistance Authority as provided in section 203 (a) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, approved April 17, 1995 (109 Stat. 116; D.C. Code § 47-392.3 (a)), a 30-day period of Congressional review as provided in

section 602 (c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat.813; D.C. Code § 1-233 (c)(1)), and publication in the District of Columbia Register.

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Chairman
Council of the District of Columbia

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Mayor
District of Columbia